APPENDIX P: SUMMARY OF ACCREDITATION ORGANIZATION STANDARDS

Scott Daniels calls meeting to order, and explains that Kaiser will go at the top of the hour because they have to get back to Washington, D.C. This is followed by introductions.

Background is given to Kaiser from Scott: In HB 2785, we have to examine quality mechanisms and private accrediting bodies. Today, we are examining the descriptive nature of the accrediting bodies: URAC & NCQA, really exploring the relationship between state oversight and the private sector. Today we will be pressing one another about the gaps of private accreditation and the strengths of private accreditation along with the issue of deeming. Scott turns the meeting over to Ann Webber from the Virginia Health Quality Center, who will be acting as facilitator for the day.

Ann explains that the group will focus their energies on learning the mechanisms of accreditation and what happens within an HMO when they are going through it. With that framework, the presentations will be gone through quickly. We should focus on where the gaps are in private accreditation, where should the public sector come in, and what are the relationships between private accreditation and public oversight of managed care.

Presentation from Kaiser Permanente: Helen Stallings

Helen explained that she wanted to emphasize the difference between Managed Care Organizations and non-Managed Care Organization as they relate to quality management. Kaiser has closed systems. Kaiser has the opportunity to control and improve thier system. Currently, Kaiser is getting ready for a mock review, so she explained that she had to leave. Kaiser is fully accredited by NCQA, and would like to discuss what they do on a day to day basis to maintain NCQA accreditation.

Kaiser has internal Quality Improvement programs as well as external affiliations with NCQA. They have a medical directors quality review which is an internal review system. The Internal Quality Management process has 2 categories: quality assurance activities and quality improvement activities. There is also periodic monitoring of quality indicators: namely the HEDIS data . Kaiser gathers HEDIS measures above and beyond the standards. Pediatric immunization rates are one example. Their immunization targets are above the HEDIS standards. Also have peer review. Kaiser also has micro level peer review among physicians. They conduct periodic monitoring of service indicators by asking questions like; can people get us on the phone, can people get appointments, do they have enough Primary Care Physicians, etc. They look at unusual occurrence reporting and investigation, for example morbidity and mortality in hospital and ambulatory settings. They also look at nursing homes for morbidity and mortality statistics, and unusual experiences. They will not contract if they find questionable behavior. They spend time on credentialing doctors, facilities they contract with, and other

providers (nursing homes, hospice etc). They also credential hospices. These can all be considered quality assurance activities.

Regarding Kaiser's Quality Improvement activities: they don't just gather data, and they make an action plan if there are unusual circumstances. Some examples are nursing homes and pediatric immunization rates. They also identify best practices: they are a closed system. If one system is operating at 98% for pediatric immunization. and is exceeding everyone else, they go in and find out why. They can extrapolate these best practices to their network of affiliated providers.

Kaiser also conducts research on new methodologies: They have the benefit of adopting new technologies. Some examples are improved biopsies for suspicious breast lesions. They conducted an in-house controlled study on the efficacy of this procedure. The procedure demonstrated the same kind of diagnostic reliability and validity as did the traditional surgical methods. Kaiser was able to learn about it, test it and adopt it.

Question : What is the process and criteria KP uses to evaluate new technology?

KP: The criteria is based on Permanente medical group and the Kaiser Foundation. It is the Kaiser doctors' job to determine medical appropriateness. It is the health plan's job to work with doctors in looking at economics. If the most efficacious treatment is most expensive, then they use it. If it is equally expensive and efficacious, then they devise clinical practice guidelines to examine it appropriateness, through research.

Question: When do the economic factors override the medical factors? How do they interrelate?

KP: Currently Kaiser is looking at issue of dexascans for treatment of osteoporosis. They are very expensive. Clinical evidence was not there a few years ago. Now it looks like dexascans with certain populations will slow the progression osteoporosis. A doctor's group came out and said they wanted this procedure to be covered for this specific population. The health plan now pays since doctors establish policy. For this group, this is the standard of care.

Question: How do you communicate the criteria to enrollees and to the provider community?

KP: When it is approved, clinical practice guidelines are distributed to providers. They have continuing education. Kaiser also puts guidelines in electronic format. For members, they have numerous member education strategies. One is an enrollee magazine. They also have a healthwise handbook mailed to every subscriber. They have posters in the medical centers,

health education classes available to members, and a website.

Question: What happens if a doctor wants to recommend a procedure for a patient that doesn't quite meet criteria, what are the grievance procedures?

KP: If a doctor says its appropriate, the patient, gets the procedure. If a doctor orders too many procedures, then they investigate whether the doctor has been effectively using health resources. If overutilization is the case, then corrective action plans will be taken. If they do not adhere to the corrective action plan, then they will be terminated.

Question: How do you train the people doing the review, and can you describe the total appeals process?

KP: We have 2 types of reviewers: UR nurses in the hospitals and doctors make all decisions regarding denials. Any nurse judgment is referred to a doctor. There are 2 types of appeals: one by doctors and one by members. We issue a statement to a member if care is no longer medically appropriate. They are told at the time how to appeal. There are different levels of appeal. Medicare members have a different track. People can appear in person to appeal. Regarding physician appeals, KP doctors always determine medical appropriateness. Affiliated network doctors can appeal through physician managers. All decisions are determined by physician managers.

Question: Can you bring your lawyer to an appeal? What is the final level of appeal?

KP: Yes, you can bring one representative. If someone is incapacitated, they can bring a lawyer. The final level is the VP for Special Services. He is from the Health Plan. Physician advisors are on all committees. In Kaiser, doctors determine appropriateness and the health plan issues denials and hears appeals.

Question: It is my understanding that the final decision for appeal cannot be made by an employee of the plan. A panel of doctors who are not employees should be on the panel.

Note: At this point, there was confusion over Kaiser's compliance with Chapter 54 of the Code of Virginia. Clarification has been recently submitted and is attached.

KP: It is my understanding that for physician appeals, there has to be an external group that would review the case, not the member physicians.

Study Group Member: The law says that the appeal can be brought by the enrollee or their representative.

KP: We have another physician group lined up and ready for cases in Virginia. Everything they talk about is addressed by NCQA standards.

NCQA Response: Kaiser does have an established standard on everything they talk about. Just to point out other Quality Improvement activities they do use on a daily basis; new technologies and continuing education. As a closed system they can require participation in Continuing Medical Education. They credential people in procedures, new physician mentoring, use of technology (electronic medical information system). This enhances continuity of care. Medical records do not go out on the internet. When I'm not NCQAing, my job is manager of clinical guidelines: these are used to define the standard of care, define quality of care based on research, not opinion. We have preventive and chronic care guidelines. If a physician is not in compliance with recommendations of a guideline and the patient population does not have outcomes they want, then corrective action is employed.

Presentation by National Committee on Quality Assurance: Steve Lamb

The New York Times this morning reads " Pioneering State for Managed Care considers Change : California Thinks Again". Virginia is ahead of California: they are only now appointing a commission like this. It is necessary to keep in mind how old some of these regulations are. NCQA standards are updated on an annual basis : the committee has consumers, providers, and other groups. Federal standards are not updated (not since 1973). One of the advantages of the private sector is flexibility the public sector does not have. HEDIS 3.0 is a collection of standardized performance measures: these are separate from our accreditation criteria. HEDIS sets standardized measures: member satisfaction rate, etc. The group that compiled it included organized labor, purchasers, and federal and state government.

HCFA says if you want to do business with them, then you have to send HEDIS data to NCQA. That allows HCFA to look at performance across regions and across states and do regional comparisons. They can tell if some areas of the country have cut back too far. NCQA accreditation standards cover six areas: Quality Improvement, Credentialing, Utilization management, Members rights and responsibilities, Medical records and Preventive health services. More and more states are saying if NCQA is doing the accrediting, let's take advantage of that.

There are now about 11 states that say as a condition of licensure you have to have NCQA accreditation. In those states, the regulators from the state departments of Health go with them on their review. Their teams are composed of physicians. Surveyors are nurses or people with a Masters in Public Health or both, but the core is comprised of physicians. This gives the state access to a set of standards that is updated regularly. NCQA also accepts public comments on their standards.

Results of their accreditation reviews are made public. For example, a person can go to the website and observe all the reviews conducted in the past 2 years: They have Accreditation Summary Reports for each Managed Care plan, and plans are ranked relative to the last 50 reviews.

Question: Are your criteria on the web also?

NCQA: Criteria are available to the public also. You can purchase the manuals and guidelines. You would want to buy the surveyor guidelines.

NCQA also has a couple of other accreditation programs. Many Managed Care Organizations have carved out Mental Health Services into what are called MBHOs; managed behavioral health organizations. NCQA has an accreditation program with an entirely different set of standards for those MBHOs. They also have an accreditation program for CVOs; credentialing verification organizations. There is some duplication which has been caused with their standards because many physicians contract with a number of MCOs. Many of these CVOs have sprung up, and most are because local medical societies choose to do this for their members. They have also come out with standards for the accreditation of Physician Organizations.

The notion of deeming is growing very fast. The House and Senate are currently passing the budget amendment. It states that where appropriate, the Secretary of Health and Human Services should be able to take advantage of the work of the private sector. Many other states have said if you want to be licensed you need an external quality review. States in the role of purchaser have also become more aggressive. You're finding states that have said that if you want to do business with us as a state, you've got to be NCQA accredited. It allows states to better focus their resources.

Question: Where are the gaps between state and private accreditation, and where do you see the state role coming in?

NCQA: The majority of reviews are annual. We are moving to a performance informed accreditation program. Our biggest gap is we don't accredit every organization. Many states have asserted that if the entity is not NCQA accredited, that tells them something about the organization.

Question: How far do states go when they establish the law?

NCQA: The better approach is to allow the regulators to decide, as opposed to legislating that.

Question: What is the minimum size an Managed Care Organization has to be in order to pursue NCQA?

NCQA: Population by itself is not a determinant. We do not set a membership level. We usually don't look at MCO unless they have been in existence for 18 months. A small plan will be challenged in the market.

Question: Will size be a barrier into the market?

NCQA: We recommend a phase -in

Question: What does it cost for NCQA accreditation?

NCQA: For a plan with 50,000 members, the base price is $36,000

Question: What happens if an HMO delegates to an MBHO that is not accredited?
NCQA: We apply Managed Care Organization standards to MBHO delegation, so it is easier for an MBHO to go through accrediting process. We also have credentialing standards for providers. We don't look through Dental HMOs persay. They credential within the organization, but not the group.

If a plan is not meeting one of the standards, they have to make progress doing what they missed.

We have a work group now internally looking to developing standards for PPMs; pharmacy management companies.

Question: Can you lose your accreditation sometime?
NCQA: Yes.
NCQA: The Mergers & Acquisitions Dept. If there are two plans that are accredited that are merging, we go on-site and do a survey. If they received a high number of consumer complaints in one area, then they investigate the review manager thoroughly. We also have a member satisfaction segment. Plan has to show they are improving member satisfaction through HEDIS.

Plans have to have an outcome: Quality Improvement results.
These results are improvements in consumer satisfactions. Most use a HEDIS measure to do that.

Question: Is there a criteria for sentinel events?
NCQA: Could be a number of things: significant change in enrollment, regulatory action.

Question: What is the timeline for adhering to regulations after a violation?
NCQA: Plans have 30 days from the notice of a regulatory violation to fix it.

Question: Can an HMO be fully accredited and still be practicing abhorrent practices? For example, routine denials.
NCQA: It would be a fundamental failure of the UR review process if that were to occur. We look at a random sample of UR denials. We also do a physician satisfaction survey.

Question: There are HEDIS measures that plans are putting in place. Is there a list of quality outcomes that NCQA requires?
NCQA: Yes, they include : What does the person report to be their own health status? Are they pleased with their service? Mortality and morbidity rates are not sophisticated enough to assess outcomes. Plans need to break

down how their physicians are paid also.

Question: Through what source does HEDIS measure quality of care?
NCQA: There are two ways we approach quality of care. One is through the accreditation standards. For example if a provider leaves the network, the HMO has to make sure the patient receives a similar provider.

Presentation by the Utilization Review Accreditation Commission - Guy D'Andrea

URAC was founded in 1990 as the Utilization Review Accreditation Commission. As they have grown, they have expanded the scope of their activities. The decision was made to adopt a name that reflected that broad scope of activities. Their mission was to bring some standardization to the Utilization Review industry. The Utilization Review industry was under criticism for inconsistency, difficulty for patients and providers to navigate, and not fully incorporating medical clinical thinking into the decision making process. The industry saw the writing on the wall and formed this organization to set standards for the industry. They recognized that for the process to be successful and to have any kind of acceptance, there had to be a broad based involvement in the process so that all the various interests were represented. So at that time, URAC had a broad-based membership. Its membership represented the entire constituency of interested parties. Members included individuals in the provider community, consumers, regulators, business and labor unions. The idea was that all these groups coming together could come up with standards applicable to all of them.

The first UR review standards were released in 1991 and were updated in 1994. To date URAC has completed a total of 500 accreditation reviews of Utilization Review management programs. That is their core business. They have also begun some new accreditation programs that reflect the growth of the industry. They have a program for networks; meaning mostly PPOs. They have accredited 21 PPOs in the country to date. They also have standards for Worker's Compensation UR Management.

In terms of putting their standards together, when URAC develops standards, they bring in specialists from the field. They have a committee process which is consensus driven. They develop a draft set of standards, which are then sent out for public comment. They do testing of the standards, and then send them out for final revision and approved by the Board of Directors. They historically have updated standards every three years. Once approved, then the standards are available for entities to apply for accreditation. The primary reason plans apply for accreditation is purchasers in the market place. Purchasers want to have some demonstration that a Managed Care Organization is committed to fair practices and quality. The secondary reason is for self-improvement. The third reason is for regulatory compliance efficiency. That starts to grow where you have multiple states that mandate private accreditation. The states may actually mandate as part of a regulatory requirement.

After an entity applies for accreditation, they submit an application which documents

their compliance that is listed in the URAC guidelines. URAC conducts an internal review of that documentation, and then there is a period of dialogue between URAC review staff and the applicant. Once there is a certain level of comfort, then there is a site visit. Once that is complete, the reviewer makes a recommendation for accreditation to the URAC accreditation committee, who then can decide what they want to do. Finally, assuming it is approved, it goes to the executive in charge of accreditation at URAC. URAC does involve all of their membership in their accreditation committee.

Guy D'Andrea displayed a list of states that URAC has affiliation/relationships with. Some have either suggested or mandated URAC accreditation. Deemed status is when a state gives a plan the option of getting private accreditation or going through the state regulatory process. Mandated status is when the review is a condition of state licensure. There are nuances in each of those broad categories.

Question: Do states use your standards of accreditation? Are state standards stricter or less strict? Are they at least as comprehensive as URAC's?

URAC: Most states that deem us have their own set of standards, but an organization that is accredited by us is not subject to the state standards. There are variations. Not all state requirements are encompassed in our standards. In some cases, the state conditions are more stringent than URAC standards.

Question: Have you ever done a side by side comparison of NCQA and URAC standards?

URAC: In the broad strokes, the standards are very close. We get into a little more detail about time frame and levels of review. In general I would say they are compatible, but not identical.

NCQA: There was a cross study done by BCBS but it is somewhat out of date

Question: When you're talking about deemed status, are you saying they are considering it deemed for UR organizations or UR components of MCOs.

URAC: It varies from state to state. Some states have stand-alone UR organizations.

Question: In your reviews, do you ever do any analysis of whether the state requirements are being met?

URAC: Certain states have UR reviews above and beyond ours. In certain states we do review their standards as well.

Question: Is your accreditation 2 years and are there different levels?

URAC: Yes, we have 2 year accreditation, and it is a yes or no decision. There are no different levels.

Question: One article I read said you are focusing on MCOs not eligible for NCQA accreditation. Can you explain that a bit?

URAC: We have developed standards for UR and networks (meaning PPOs). We developed standards more suited to the PPO industry. We found the industry is quite diverse. The cream of the crop apply for our standards.

Questions for Both

What is your organization's official position on whether or not states should make your accreditation deeming for mandated?

NCQA: The relationship we have with states is more beneficial to them than to us.
URAC: The only caution we would have would be to not tie the state's hands. The licensure decision should remain with the regulator.

URAC: Our PPO standards look at credentialing and member protection etc. The other end of the spectrum are PPOs that contract physicians. About 1/2 of the states don't even try to regulate the arrangements.

NCQA: We are holding HMOs at very high standards, but there are more people that are in PPOs. Before contemplating a whole new set of regulations for HMOs, we would like to survey the PPOs in Virginia and what kind of medical management techniques they are using. We do not want to focus on one part.